

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-034990

STATE FILE NUMBER

Registration District No. 10

Primary Registration District No. 3002

Registrar's No. 1

DO NOT WRITE
ON THIS STUB

AMENDED

FILED OCT 14 1963

1. PLACE OF DEATH a. COUNTY <u>Audrain</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Montgomery</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Mexico</u>		c. CITY OR TOWN <u>Wellsville</u>	
Length of stay in 1b <u>8 days</u>		Inside Limits <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Audrain Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>300 S. 2nd. St</u>	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Katherine</u> Middle <u>Mary</u> Last <u>Schulz</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>6</u> Year <u>1963</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>July 14, 1887</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house keeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11. BIRTHPLACE (City and state or country) <u>Wellsville, Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>William Schulz</u>		13b. MOTHER'S MAIDEN NAME <u>Catherine Spitzhern</u>	
14. NAME OF HUSBAND OR WIFE <u>Rudolph Schulz, Wellsville, Mo</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	
16. SOCIAL SECURITY NO. <u>[redacted]</u>		17. INFORMANT Address <u>Rudolph Schulz, Wellsville, Mo</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchial asthma</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <u>1960</u> to <u>Death</u> and last saw <u>her</u> alive on <u>10-6-63</u> Death occurred at <u>4:40 A.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.		22. SIGNATURE (Degree or title) <u>MD</u> 22b. ADDRESS <u>Mexico, Mo.</u> 22c. DATE SIGNED <u>10-7-63</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Oct. 8, 1963</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Wellsville</u>		23d. LOCATION (City, town, or county) <u>Wellsville, Mo</u>	
24. FUNERAL DIRECTOR <u>Howard F. Myers, Wellsville, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>10-10-63</u> 26. REGISTRAR'S SIGNATURE <u>Alberta Edmonston</u>	

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

000170-870

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____ Student Embalmer No. _____
working under my personal supervision.

Student Paul Arena
Signature of Student Embalmer

Signed Howard Myers

Licensed Embalmer No. 4494

P. O. Address Wellsville, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.